Community Connectivity: A view from the "bottom up"

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NPN Northwest Physicians Network
An Independent Physicians Association

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Key Points

- A "bottom up" perspective of implementation
- Clarify definitions from the view of independent community physicians
- NPN's experience getting community physicians to adopt HIT
- Leaving out some things for now
  - PHR's, CDR's, RLS's, etc
  - Doesn't mean they're not in here – they are, but they're not the focus of this presentation

Competing approaches to implementation of HIT

"Bottom up"

- Micro-level engagement
  - Physician's office
  - Work flow re-design
- "Retail" stakeholder development
- Centered on small clinics of 9 or fewer
  - 80% of physicians in country
  - Very low level of capitalization

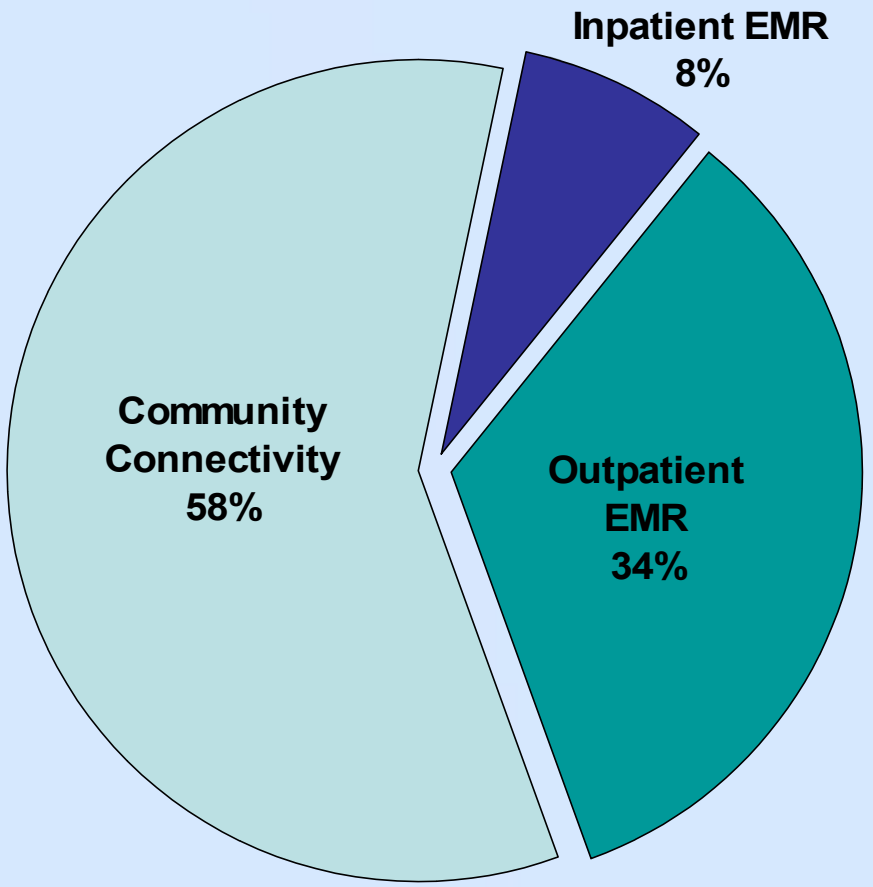
Competing approaches to implementation of HIT

"Top down"

- Macro-level engagement:
  - Governance before the 'governed'
  - Financing before budgeting
- "Wholesale" stakeholder development
- Centered on larger health institutions
  - Plans, hospitals, etc
  - Highly capitalized
  - Less well rec'd by public than "family physician"

Where the savings come from

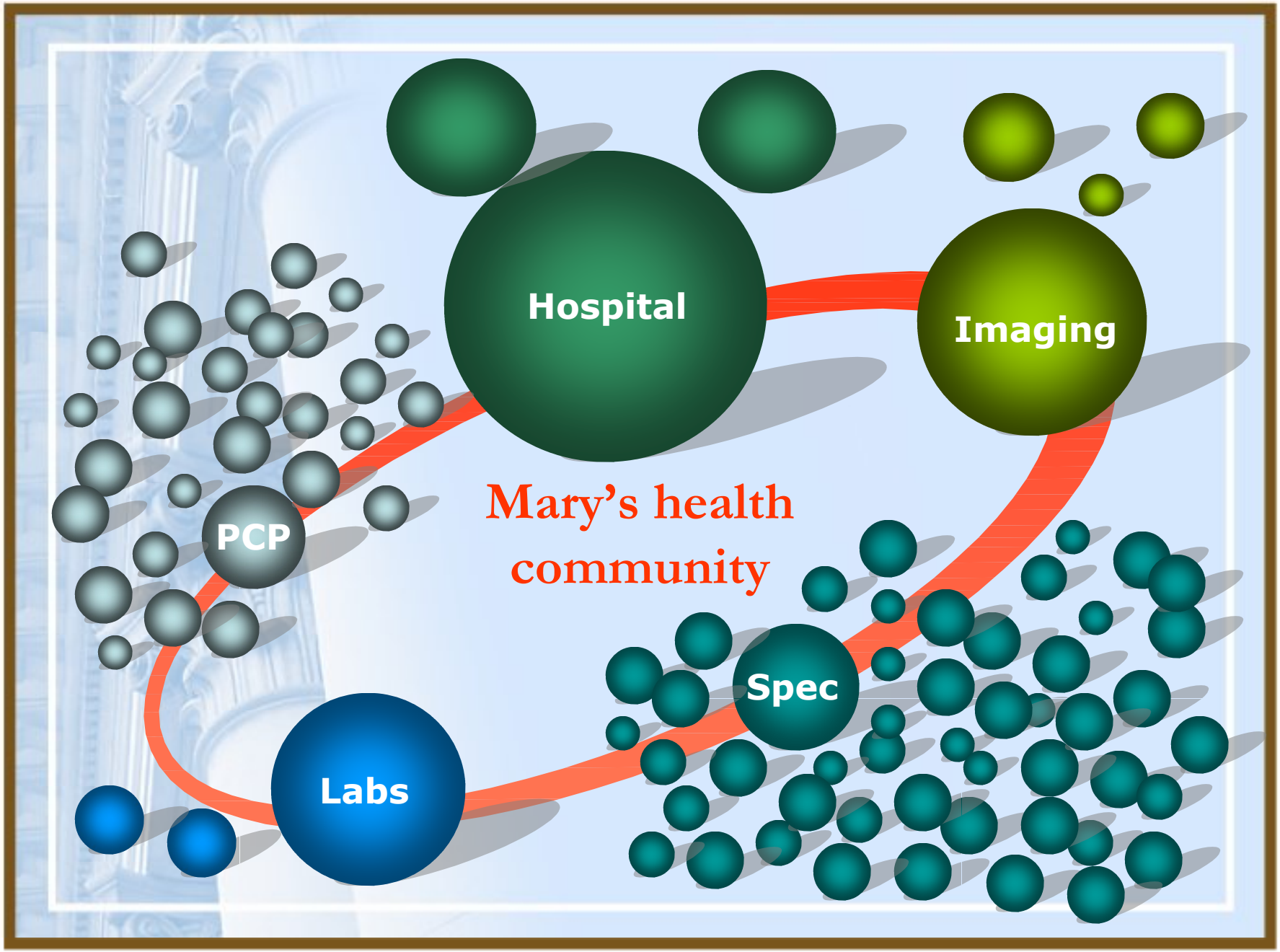
- EMR utilization & Community Connectivity don't mean the same thing
- They are complementary but separate & distinct



Source: Center for Information Technology Leadership, Partners Health Care, Harvard (2004) as presented by NHII Advisors to HIISAC, Jan 2005

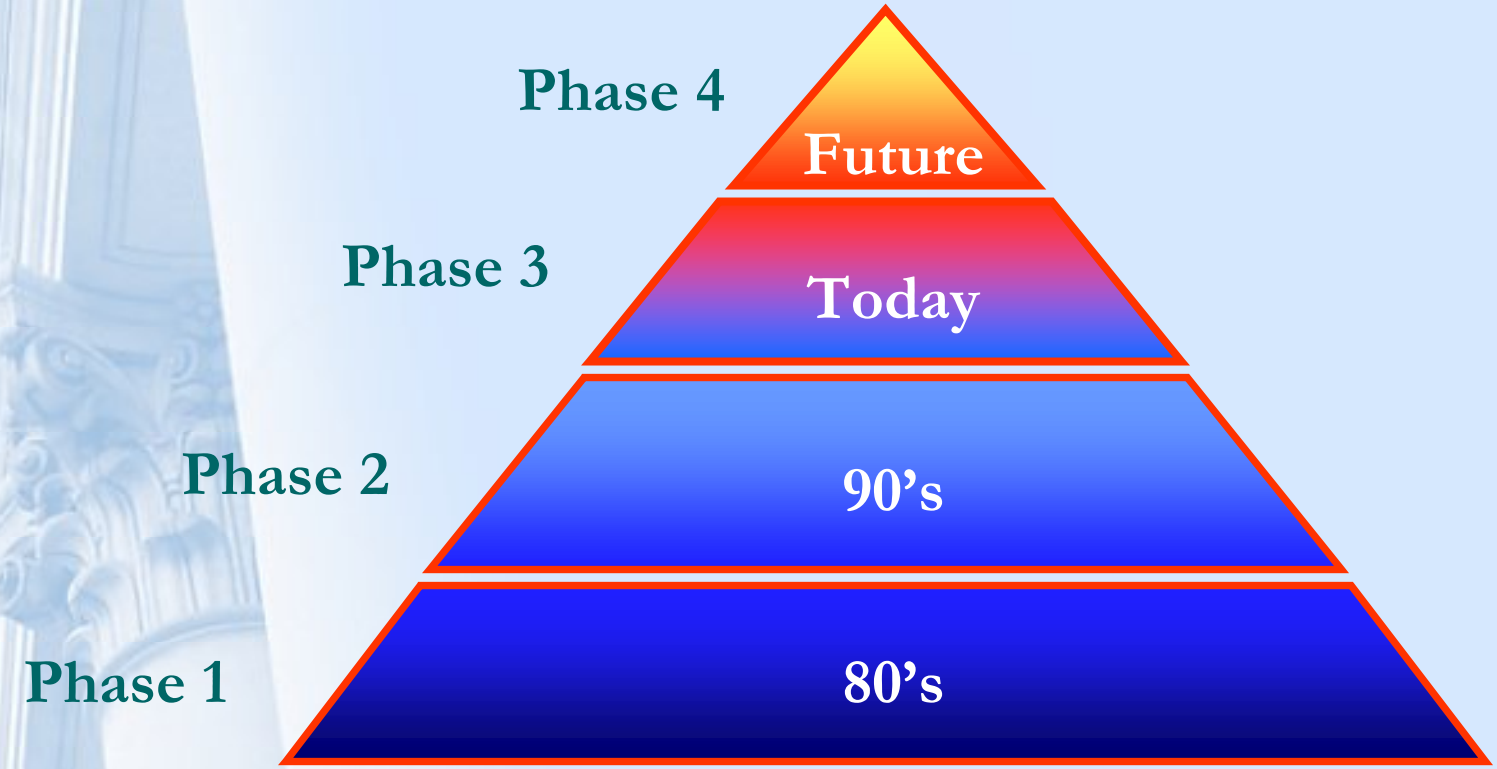
So, what do we mean by "Community" when we talk about connectivity?

- Medical community mapping example
- WSMA survey
  - 'My hospital'
  - 'My medical group'
  - What about the competition?
- What about low income providers without an EMR?
  - Do you need an EMR to play?
  - Does this become a barrier to being part of a "community"?


Hospital
Imaging
PCP
Mary's health community
Spec
Labs

- Too much focus on interoperability? Perhaps…
- It's because the conversation takes EMR's for granted
- It's assumed that EMR adoption is required for interoperability and that the difficulty is getting them to talk
- Not necessarily the case

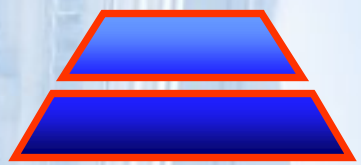
Getting the "Community" Connected: "Bottom Up" Implementation



Phase 1: "Catching up with the 80's"

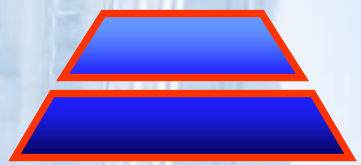
- Modernize the workplace
  - Computers in the office
  - High speed internet
- ROI has become self-evident, but not often numerically measured
- Savings is in FTEs, workflow
  - 7th floor secretarial pool
  - Travel agencies

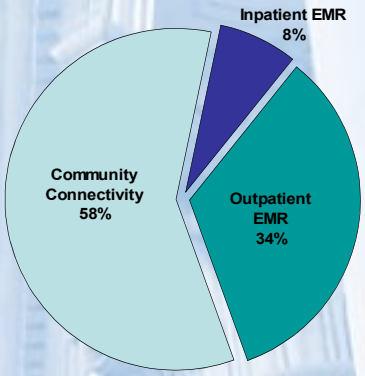
Phase 2: "Catching up with the 90's"



- Relies on the standardization battles already waged – Microsoft won
- We're talking about trading emails, jpegs, text files
  - *Secure communication* between PCP, specialists, hospital, clinics, etc
  - Scan it in, save it on the hard drive & paper file, and send it off
  - Stored in a patient's or a provider's online file
- Critical, clinical data at front line of care
  - Labs, radiology, allergies, prescriptions
  - Not every bit of info ever created – just what's needed at that moment

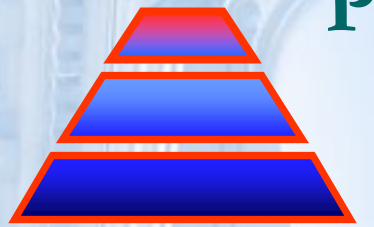
Phase 2: Catching up with the 90's



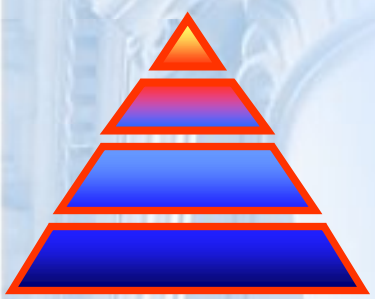


- ROI is overwhelming
  - 8.5:1 return on first year alone
  - $4000/physician in first year
  - $2100/physician in each later year
- Reconfigures work flow – just like Phase 1 adoption
- $$$ is in savings– new revenue can come from new patients later, if desired

Phase 3: Adopting EMR's – Today

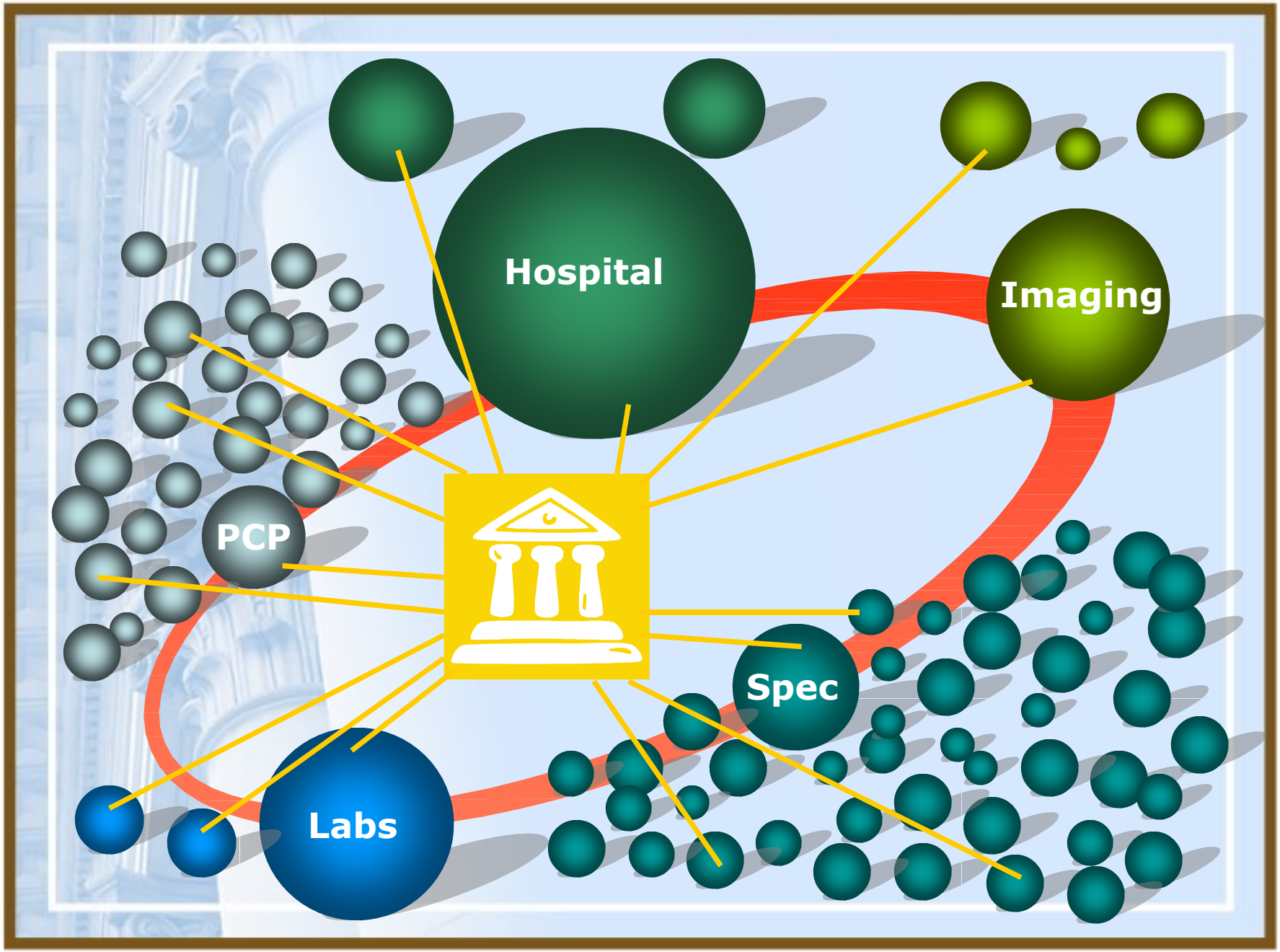


- Use savings from workflow to implement EMR adoption
- EMR as <u>library only</u>
  - Critical definition
  - Can do things with a library
    - Check out books, store data, etc
    - Library card is authentication, credentialing
    - Book is the data; sharing is the value
    - The EMR doesn't share – it stores
- Cleans up hard drive, saves on transcription and all of that – but another mechanism does the sharing



Phase 4: The Future

- Real time access to lifetime health information on any patient which may or may not present for care
- Automatically sharing EMR-stored data sets across a connected community
  - This is the conversation about a CDR, MPI, RLS, etc
  - Can't yet agree on how, how much, etc but we know we're trying to get there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Conclusions

- Community Connectivity does not need to mean EMR – and EMRs alone cannot mean Community Connectivity
- "Community" by definition: Must also include the 'least among us' – independent physicians & nurses
  - Don't let architecture become a barrier to entry
  - Defeats the purpose of your efforts

Observations of HIIAB

- Focus has been on "Top Down" and "Phase 4"
  - "Bottom up" & "Phase 1" has not had much attention in this forum
  - Solution probably should be a balanced mix of both – which HCA is doing beyond HIIAB
- Conversation on interoperability assumes EMR adoption is a precursor to communication & it doesn't have to be
- Must be extra clear about definitions, whether in this setting or the public
  - "EMR"
  - "Community"
  - "What did we agree to?"

Don’t let perfection become the enemy of progress.

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